



DEVAL L. PATRICK
GOVERNOR
TIMOTHY P. MURRAY
LT. GOVERNOR

The Commonwealth of Massachusetts

Executive Office of Health and Human Services

Commission for the Blind

48 Boylston Street, Boston, MA 02116-4718

JUDYANN BIGBY, M.D.
SECRETARY
JANET L. LaBRECK
COMMISSIONER

VOLUNTEER APPLICATION

1. NAME: _____ DATE: _____
2. HOME ADDRESS: _____ CITY: _____ ZIP: _____
3. BUSINESS ADDRESS: _____ CITY: _____ ZIP: _____
4. HOME TELEPHONE: _____ BUSINESS TELEPHONE: _____
5. EDUCATION AND SPECIAL TRAINING: _____

6. VOLUNTEER EXPERIENCE: _____
7. INTERESTS, HOBBIES & SKILLS: _____
8. FOREIGN LANGUAGES (SPEAK? READ? WRITE?): _____
9. SIGN LANGUAGE: NO? _____ YES? _____ HOW MANY YEARS? _____
10. ANY LIMITATIONS: _____
11. VOLUNTEER ACTIVITY DESIRED

_____A. READING
_____B. DRIVING
_____C. TUTORING
_____D. RECREATION
_____E. SHOPPING
_____F. FRIENDLY VISITOR (in person)
_____G. FRIENDLY VISITOR (by phone)
12. TIME(S) AVAILABLE
MORNING-AFTERNOON-EVENING?
MONDAY _____
TUESDAY _____
WEDNESDAY _____
THURSDAY _____
FRIDAY _____
SATURDAY _____
SUNDAY _____
13. DO YOU SMOKE: YES?__ NO?__ DO YOU MIND OTHERS SMOKING?__

The following information is requested of volunteers providing transportation.
14. DRIVER'S LICENSE NUMBER _____
15. NAME OF INSURANCE COMPANY _____
16. LIST ANY ACCIDENTS AND/OR CONVICTIONS IN THE PAST 3 YEARS (EXCLUDING PARKING TICKETS) _____
17. I AUTHORIZE MCB TO VERIFY AT ANY TIME MY DRIVING RECORD FROM THE REGISTRY OF MOTOR VEHICLES.

SIGNATURE: _____ DATE: _____

18. PLEASE LIST YOUR PAST AND PRESENT PROFESSIONAL EXPERIENCE:

TITLE OF YOUR PRESENT OR MOST RECENT POSITION: _____
NAME & ADDRESS OF YOUR EMPLOYER: _____
KIND OF BUSINESS: _____ EMPLOYED FROM _____ TO _____
DESCRIPTION OF YOUR DUTIES: _____
TITLE OF NEXT PREVIOUS POSITION: _____
NAME & ADDRESS OF EMPLOYER: _____
KIND OF BUSINESS: _____ EMPLOYED FROM _____ TO _____
DESCRIPTION OF YOUR DUTIES: _____
19. HOW DID YOU RECEIVE INFORMATION ABOUT THIS VOLUNTEER POSITION? _____

20. PLEASE STATE WHAT YOU BELIEVE TO BE YOUR STRONGEST QUALIFICATION FOR THE POSITION? _____

21. PLEASE LIST THREE (3) PERSONS, INCLUDING YOUR MOST RECENT EMPLOYER, WHO HAVE CLOSELY OBSERVED YOUR WORK LISTED UNDER EXPERIENCE:

<u>NAME OF SUPERVISOR</u>	<u>TITLE</u>	<u>NAME/ADDRESS OF COMPANY</u>	<u>PHONE</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
22. GEOGRAPHIC LOCATIONS WHERE YOU ARE WILLING TO WORK (PLEASE CHECK)
REG 1. SPRINGFIELD/WESTERN MASS____ REG 4. GREATER BOSTON____
REG 2. CENTRAL MASS____ REG 5. SOUTHEASTERN MASS____
REG 3. NORTHEASTERN MASS____ REG 6. BOSTON – BROOKLINE____
23. IN WHICH REGION OR AREA DO YOU PREFER TO WORK? _____
24. I hereby certify that the facts set forth in the above volunteer application are true to the best of my knowledge. I understand that if I am accepted for MCB's volunteer program, I may be subject to dismissal if I have falsified statements on this application. All schools, employers and other references are authorized to furnish full information about me to the Massachusetts Commission for the Blind. Further I understand and authorize the Commonwealth to perform a Criminal Offender Record Information (CORI) check.
25. E-MAIL ADDRESS: _____

SIGNATURE: _____ DATE: _____

Please return to: randall.pinch@state.ma.us